

COMMISSION ON THE PROBLEMS OF MENTALLY RETARDED, HANDICAPPED
AND GIFTED CHILDREN

January 13, 1960

The meeting of the Commission on the Problems of Mentally Retarded, Handicapped and Gifted Children was held Wednesday, January 13th, 1960, in the Court House on the second floor of the Isanti County Court House at Cambridge at 9:30 A.M. The afternoon meeting consisted of a tour of the Cambridge State School and Hospital by the Commission members.

Chairman Warnke called the Commission to order. Roll was called and a quorum present as follows:

SENATORS

Fay George Child
Karl F. Grittner
Clifford Ikkelberg

REPRESENTATIVES

Moppy Anderson
Lawrence P. Cunningham
Curtis B. Warnke

Absent: Senator Walter J. Franz and Senator Stanley W. Holmquist and Representative Ernest Beedle and Representative George Wangersteen.

Also present at the meeting was the Honorable Ralph E. Johnson, State Senator from Isanti County, Dr. Galin Adkins, Superintendent of the Cambridge State Hospital, and Frances Coakley, Supervisor of Mental Deficiency and Epilepsy from the Minnesota Department of Welfare.

EXECUTIVE MEETING REPORT

Chairman Warnke reported that the Executive Committee met for a dinner meeting at the Criterion on January 12th. Those present were Senator Grittner, Mr. Warnke and Mr. Anderson. They felt it was not necessary at the present time to hire an Executive Secretary but that after gathering more information they could then hire someone to draft the report.

SENATOR CHILD MADE A MOTION THAT THE REPORT OF THE EXECUTIVE COMMITTEE BE ACCEPTED AS REPORTED. SECONDED BY SENATOR IKKELBERG. MOTION CARRIED AND SO ORDERED.

MR. WARNKE: At the last meeting you instructed me to contact Congressman Carl Elliott, Chairman of the Subcommittee on Special Education, in regard to the findings of the Subcommittee and the possibility of their holding a meeting in this area. I have a letter from him saying "We will certainly see your Committee gets the findings as they appear from time to time."

Mr. Elliott further says "We will keep very much in mind your gracious invitation to come to Minnesota and as our plans shape up after the Congress is in session, if we find a hearing in your State can be arranged, we will be in touch with you." I will keep you posted on this.

MR. JERRY WALSH, Minnesota Association for Retarded Children. Thank you Mr. Chairman. We are happy to be able to continue our presentation which we started at your meeting last month. We appreciate the great amount of time that you are giving us.

I would like to briefly remark about our presentation at your last meeting, and perhaps change the impression that we gave at that time, the feeling that was written up in the minutes and shown by us is not exactly the true picture. You will remember that John Holahan discuss at some length the waiting list, how long it was, and how if you did not take your turn when it come up perhaps you would not get another chance for four or five years. The discussion went on for several pages, at one point John said, "The policy as it stands - you must take your turn as it comes up, you may have to wait 3, 4 or 5 years before your chance comes up again, I think it tends to impose an institution alternative to the problem of the parent a little more so and a little sooner than might be the case if there was a greater degree of flexibility for the admissions policy." The Welfare Manual on page 43 which you have points out -

"If institutional space is refused and at a later date the family finds institutional plans are advisable, precedence will be given over later commitments. If the situation can be termed an emergency, immediate institutional placement will be offered if possible."

This has been my understanding of the way the policy has worked, that if a person refused space when it was offered that they do not have to go to the bottom of the list and wait three or four more years but would be given preference because they have already waited. If they change their minds in six months or a year they would be given preference and would not have to wait through the list again. This certainly does give a degree of flexibility to the waiting list. I just want to mention that because that I think the way we told it would not be correct.

SENATOR CHILD: What is the waiting list now?

MR. WALSH: 1319 as of December 1st.

SENATOR CHILD: MR. HURSH pointed out the other day that this list would be probably 25% less - it would go downward to possibly somewhere around 800.

MR. WALSH: Yes. But until the place is offered the department cannot make a definite statement. They have not had enough years of experience to be able to say 25% will refuse to take. They do not know. I think it a difficult point to make a definite statement on. I will speak of that this morning in regard to Faribault.

On September 9, 1959 Mr. Hursh, Commissioner of Welfare, and on October 14, 1959, Dr. Dale Cameron, Director of Division of Medical Services and Miss Frances Coakley met with the Commission and outlined several areas where the Department felt there was need for improvement in the program for the mentally retarded. (we will use the term mentally retarded synonymously with mentally deficient, the legal term) and therefore suggested that the Commission consider these areas for study. The Minnesota Association for Retarded Children wishes to record its agreement with the Department and to reinforce the statements made by Mr. Hursh and Dr. Cameron. We agree on most everything - it happens that we both see the same problems - it isn't that we are going out of our way to agree but we do happen to recognize the same things that are most important. We are presenting some material today we hope will help the Commission better understand the basis of the suggested requests. Unless the Commission will have secretarial service to secure further information on what is done in other states - including costs this Association will try and secure it. In fact we have already written to some states asking for information, but have not received answers to the letters.

We will take up the six areas covered by Mr. Hursh, some of these having also been covered by Dr. Cameron.

1. Mr. Hursh discussed staffing at the institution. We have a separate report showing especially the needs at Faribault and have put the emphasis on aides although the ratio of patients to the different categories of professional staff should also be considered. We are trying to secure more up-to-date comparisons in this field for your consideration; in fact we have obtained as yet unpublished figures from the Federal Government (National Institute of Mental Health) showing the ranking of the midwest states for the year 1955-1956 as regards the number of patients in institutions for the mentally retarded in relation to the number of all permanent employees, this would include carpenters, painters, and everything - people who do not care for the patients. That is for each permanent employee there are the following number of patients:

Kansas	1.8	Ohio	3.6
Wisconsin	2.5	Minnesota	3.7
Michigan	2.8	Nebraska	4.3
Indiana	2.9	Illinois	5.6

This ranges from Kansas where each employee is expected to take care of 1.8 patients to Illinois where each employee is expected to take care of 5.6. Also, as was pointed out last time we must recognize that it takes 4.75 to fill any one position so that really when we talk about there being a 1.8 patient per employee we have to multiply that by roughly 5 so that it would be roughly 10 to 1.

It will be noted that in these eight midwest states we are third from the bottom in what might be considered adequacy of service, certainly based on the personnel. I think our other studies certainly very much bear out the fact that we stand pretty much at this point as compared with other states.

It must be remembered that these figures represent the over-all picture for all the institutions. It seems very important to the Minnesota Association for Retarded Children that the Commission give consideration to making certain that the institutions be staffed and equipped on a comparable basis. As each serves a region of the state all parents should have confidence that one institution is not inferior to others.

In the report on Faribault we are also making further recommendations relative to the school program and food service.

II. In regard to this second item of Mr. Hursh's, and one which Dr. Cameron also discussed - out-patient diagnostic service - the following facts should be called to your attention: Many states or communities feel that clinics should be established just for the purpose of diagnosing mental retardation and then providing therapy. On the other hand, the law passed by the Minnesota Legislature in 1957 making it possible to subsidize mental health clinics 245.61 - 245.69, would seem to be sufficiently broad to include a good program for the mentally retarded. However, it has been the experience of persons with primary interest in the mentally retarded that these clinics are definitely oriented toward the mentally ill and not the mentally deficient although some service is given this latter group. It is a question whether their use for the mentally deficient is a matter of education and administration or whether clinics for diagnosing the mentally retarded--especially children--should be established. Possibly counties should be subsidized for additional staff in these clinics with special responsibility for the retarded.

I think it was about a year ago I wrote to Morris Hursh after looking at the law that made it possible to establish mental health clinics and said would not it be possible to establish say a day care center for retarded and draw money from the state based on this law, and he said yes it would but we don't have the money. The money just is not there. We just allocated enough money for the mental health clinic.

SENATOR CRITNER: Custodial day care.

MR. WALSH: It would be day care, whether you would want to call it custodial day care - care - it would also give the children a great deal of help. We are not thinking of strictly baby sitting, there is quite a bit of training that these children can get in a day care center.

SENATOR CRITNER: That is interesting to me that this actually encompassed in the law.

MR. WALSH: The law is fairly broad.

SENATOR CRITNER: This was not my legislative intent.

MR. WALSH: Looking it over carefully you can see that it could be done. I don't think it was the legislative intent.

SENATOR CRITNER: The legislative intent was to try to take care of mental health clinics.

Mr. Waltz:

There is, however, another type of clinic discussed especially by Dr. Cameron to be considered. In many states the staff at the institution conducts clinics for those who may or may not be considering institutional placement. In Minnesota this type of clinic has been considered, but since there is not now sufficient professional staff for adequately serving patients, it would seem that there would be no question of establishing a clinic of this type without additional staff. The Association suggests that consideration be given to the question of providing additional staff by authorizing the commissioner and an institution superintendent to cooperate with the public officials of a group of counties and/or private agencies to set up such a clinic. The institution would provide space for the clinic, over-all direction and consultation services while the public agencies and/or private agencies would pay salaries for needed professional personnel.

It is certain that more diagnostic and treatment service is needed. The Department of Public Welfare has traveling psychologists whose services are available to the counties to the extent possible, but more study is needed in a large number of cases than they are equipped to give. Many of those thought to be retarded are difficult to diagnose and neither the University of Minnesota nor the Mayo Clinic can supply the amount of service needed. You will surely recognize that the University of Minnesota is a teaching institution and when they do diagnosis regarding the retarded they can only take the number of cases that will tie into their teaching function. This is all they should be doing or otherwise they would be strictly a service agency. They are limited in the number of retarded they can serve.

The worthwhileness of institution clinic service can be attested to by Dr. E. J. Engberg, Superintendent of Faribault State School and Hospital, I am sure, as I am told he gave the service of his staff in two particularly difficult situations.

While Minnesota has never waited for other states to take the lead in establishing new programs or giving needed service - as for instance the 1917 laws concerning children and mentally deficient - it is certainly of interest to know when other states are giving greater or better service than Minnesota in certain areas. Some of the states where institutions give diagnostic service are California, Massachusetts, and Indiana at least at the Fort Wayne institution.

III. The next point made by Mr. Hursh was the need for enlarging the program of day activities for the mentally retarded. These various services make happier and better adjusted individuals and happier homes, and I am sure every parent who has had such service would document this statement. The well being of its citizens is a concern of the state, but it is the belief of this agency, and I am sure of the Department that day time activities will frequently obviate the need for institutional care at least for a period of years.

(Please note the footnote which ties into your question - Figures just received from Faribault indicate that space offered to fill vacancies to be made by transfer of patients to Brainerd was refused for 22 percent of the males and 35 percent of the females and that these are largely in the groups of ambulatory children under 10 years of age. It seems likely the day care centers now in existence are having an effect.) Thus from a tax angle it is important to give

consideration to any action that would affect the need for more and more capital outlay in constructing new institutions. Is it possible that such service could be provided for the retarded under the present terms of the law establishing mental health programs? If so it would need only an additional appropriation for matching funds. The Department could then authorize funds on a very selective basis and keep careful records for comparison with other counties to determine the relationship of the adequacy of community facilities to the use of institutional space. We have some information relative to subsidies provided in other states, but hope to get more.

Delaware establishes such centers at state expense. They are organized and supervised by the state institution. \$60,000 was appropriated for the fiscal year ending 6-30-58 and \$65,000 for the next year (Mimeographed report of M. A. Parumianz, MD, Superintendent, 11-17-58). Connecticut--passage by the 1959 legislature of a bill authorizing subsidies for day-care classes, training, and sheltered workshops and diagnostic clinics in the community. \$250,000 was appropriated for current biennium. (Report by President of Connecticut ARC in "Children Limited" for December 1959.).

This we feel is a very important area to consider - the question of the community facilities, state subsidy for them, the relationship of the community facilities to the need for new institutional space, the relationship of the cost to the state. If more of these children can be cared for in the community we definitely feel it would be quite a bit less if they can be cared for in the community than building new institutions and then taking care of them in the institutions.

IV. The next area recognized by Mr. Hursh is that of the need for financial aid to counties who must place retarded or epileptic wards in boarding homes or private residential facilities. Minnesota Statutes 260.38 provides for reimbursement to counties for up to one half of the cost of boarding home care for children committed as dependent or neglected. The Commissioner can now do this.

There are several points I should like to make here relative to this same provision for the retarded:

1. The retarded children referred to are wards of the Commissioner and he has a special responsibility to them.
2. At this time the children boarded are those whose families cannot keep them at home without hardship on other members of the family. Some of you, I am sure, have seen a home situation where this hardship existed.
3. The cost in boarding homes is high for these children who are difficult to care for and few families even in very comfortable circumstances can afford payment for long. The cost ranges usually from \$100 - \$150 per month with clothing and medical care in addition. In 1935 the then Board of Control secured opinion from the Attorney General placing responsibility for payment upon the local tax unit.

Figures given by the Department of Welfare show that in October 1959 (the last month for which statistics are available) there are 325 children in the residential facilities caring for children of this type. This would mean boarding homes and in group care facilities outside of state institutions. There are not figures available to show just how payment is divided between families and money raised through taxes, but it is probable that the families are paying much less than half of the total cost. The figures showing what the counties actually pay can be obtained by the Department if you wish them. It would take time because in many instances the county pays the boarding home, but the parents pay to the counties a portion of the cost. Mr. Hursh stated that the 1959 legislature was asked for \$275,000 for the biennium which would appear to be the minimum amount needed considering the range of monthly rates and the number of children boarded.

4. When the family or county is paying for boarding care, it is rare that a child is not placed in an institution when space is offered. Often the boarding home adjustment is good and the child could well remain there for a longer period of time. State reimbursement for a percentage of county costs might delay entrance for at least a number of children.

5. Other states have not so far as can be ascertained developed a system of boarding homes or residential facilities of the type Minnesota has. However, some states pay for private institution care if a child cannot be accepted in the state facility due to lack of space. One of these is South Dakota.

V. Mr. Hursh's fifth point is the possible need for grants in aid to County Welfare agencies to enable them to add staff to improve services including supervision to the mentally deficient. I doubt if anyone who has not had close contact with the mentally retarded has any idea of the amount of time consumed to explain even a simple process or idea to him. This means real assistance in adjustment, for one individual may require hours of the time of a social worker. But if retarded persons are to remain in or return to the community as assets, this time must be given. In order to do this an adequate number of social workers is needed and grants in aid may be required to meet the need.

Most states do not have a county-center over-all plan for the retarded as does Minnesota. In most states when a retarded person is returned to the community from the institution, supervision is given by a special worker employed by the institution and thus at state expense. It is true supervision in those states may not be extended more than a year or two and Minnesota extends it, because of guardianship, as long as it seems to be needed. The Minnesota Association for Retarded Children believes this is a better plan. Supervision by county welfare boards means that many persons may remain in the community or return to the community if facilities are provided as outlined in the earlier items for consideration.

There is an additional problem in planning for placement and supervision. This is information obtained from records of the Department of Welfare and County Welfare Agencies. Because of the place where work is available for a ward capable of at least partial self-support or for other reasons, there are times when he should be supervised in a county other than the one in which he has settlement. This means some counties must give service to persons for whom in one sense of the word they do not have legal responsibility. The time comes when a county protests placement and thus a ward is deprived of adequate service. An example of what may happen, the total case load of Hennepin County is 1055 but 140 are from other counties - which is 13%. The total case load of Ramsey county is 820 but 85 are from other counties. Figures from rural counties are not so striking, but there are some who have one or more out-of-county wards and usually these are the ones requiring the largest amount of supervision.

Another phase of this question of supervision by a county other than that of legal settlement is the responsibility of a county welfare agency for supervising and sending reports on children placed in a residential facility in the county, such as Mr. Hursh spoke of as point IV. Some of these house as many as 20, 30, or 40 children from all over the state. Should a county have the power to veto over having a facility opened? Then if it says it cannot supervise them, the children will be deprived of living with someone who might give them good care. Or shall the state give a grant to the welfare agency so that it may have adequate staff?

There are few states which can really be compared to Minnesota in this area, as what supervision most states give is by social workers employed by state institutions except where it gets voluntary cooperation from local, public or private agencies. Of course in cities of these states where there are private agencies serving a variety of problems, service will be given to many retarded persons and their families. The same is true of their county agencies which have general responsibility for meeting problems, but a centralized, state-directed, county-administered program does not exist in a form to make comparison proper here.

VI. There is a sixth item that Mr. Hursh recommended should be given consideration - a change in the collection laws for institutional care. Dr. Cameron touched on this and Dr. Maynard Reynolds also spoke strongly in favor of a change in the bill on pages 15 and 16 or 51 and 52 (according to whether the numbering is taken from the bottom or the top of the page of the October minutes). Dr. Reynolds called attention to the fact that many states use a portion of the amount collected for research and training purposes. A bill was introduced in the 1957 legislature which embodies many of the principles this Association thinks should be in a law. The Association agrees with Mr. Hursh that changes should be considered. At this point, however, we are not in a position to make further recommendations on specific points.

VII. This Association would like to urge that this Commission give consideration to some method of making funds available for research. Not only is there much to be learned concerning causes of retardation and epilepsy, but also diagnosis and methods of caring for and training those who are retarded or epileptic.

A good research program, it seems to us, is justified on four bases:

1. It may eventually mean the prevention of some types of mental deficiency or epilepsy or its amelioration.
2. It will mean happier and better adjusted individuals.
3. It may eventually save much financial expenditure both because of prevention and adequate adjustment.
4. It has been found in institutions with research programs that staff members are stimulated and that it is sometimes easier to secure competent persons. This would also apply to central office staff, we believe.

And now a final word. In placing the Minnesota Association for Retarded Children on record as being in favor of appropriations for research and for certain aids to counties or agencies, as recommended for consideration by Mr. Hursh, we are in line with what other states are recommending. Many states have had commissions appointed during the past 6 or 8 years to study programs for mentally deficient and report to the governor or legislature. For instance, the Illinois Commission on Mental Retardation transmitted its report to the Governor on December 22, 1958. It recommended an over-all state coordinated program; services of social workers or trained counselors, to families in the community, and without institution contacts and these to be provided "through legislative action and adequate appropriations to the appropriate agency of the Illinois Department of Public Welfare"; supportive help to local mental health centers and child guidance centers in order to provide diagnostic services; expansion of the institution program and some other agencies to provide greater diagnostic services; financial assistance for local day care centers and other facilities.

The Illinois report has five pages on research with specific recommendations. We might end by quoting a sentence in the introduction - "In the future a high priority should be given to the development and direction of research programs because in the final analysis, it is only through research that mental retardation will eventually be eradicated." Perhaps eventual eradication is too bright a hope, but certainly without much research little improvement can be made.

This report from the Illinois commission is in line with others and thus it would seem Minnesota is following the current trend in seeking to give better service to the retarded by providing more state financial aid as well as by developing research programs.

In these recommendations we have adhered only to those pertaining to programs for the retarded and epileptic under the direction of the Department of Welfare. However, Mr. Cehrke of Vocational Rehabilitation has appeared before you and the work of his division is closely related to that of the Department of Public Welfare. If community placement for the mildly retarded is to reach maximum efficiency, there must be assistance from vocational counsellors. We hope consideration will be given to appropriation requests in order that an adequate number of counsellors may be assigned to serve the institutions and the staff of the county agencies.

There was a brief discussion by the Committee and Mr. Walsh on the fact that many of their recommendations were the same as that of the Department of Welfare. It was further pointed out that many of them were a national trend.

SENATOR CRITTEBER: How many of the states have an Association so that you have an interchange of information?

MR. WALSH: All of the states have Associations.

SENATOR CRITTEBER: How many of them are staffed as adequately as Minnesota?

MR. WALSH: Minnesota is probably, in so far as development and staffed, one of the top in the country - New York and Massachusetts, Michigan and Minnesota are at the top.

I have further comment in regard to Cambridge State School and Hospital. A committee of our Association met with Dr. Adkins and his staff last Saturday. Our Committee consist of parents... of retarded children, some having their children at Cambridge and some at Faribault. There were five of us from different parts of the State, all active over a period of years in the Association. Most of these people have children 8 or 9 years old and have dealt with the problem that long, very stable people, one a mechanic, an aeronautical engineer, one has been a school teacher, etc. We try very much in our Association, we know that parents of retarded children have many emotional problems but usually the ones that are working on our Committee are well adjusted. We spent the day with Dr. Adkins.

We have outline three major areas - Staffing, Over-crowding and Medication and Drugs. In STAFFING we say this - Approved compliment for Cambridge is 545, present staff totals 552, with a ratio of 3.6 which ties in pretty much with our state average.

The administrator at Cambridge feels that additional custodial workers and food supervisors would make it possible for the aides to concentrate on patient care and training for which they have been employed and trained. The idea of adding employees in these two areas is very worthy of study.

It is the feeling of our committee that the aides can do no more than handle the barest needs of the patients under the present set-up. It makes little sense to train people as aides and then have them spend a substantial portion of their time doing unrelated work such as cleaning, sorting clothes, making beds, etc. It may be that custodial workers could do simpler tasks in patient care under the direction of the aides. This is the type of thing that has been done by the high grade patients in the past.

Cambridge has other staff needs which need a study also.

It is our feeling that ratios of employees to patients must be adjusted in consideration first of the degree of retardation of the patients, and further in consideration of building type. We have very many different types of buildings in our State where the retarded are housed, two story, one story, a very interesting building at Faribault, a Swiss chalet type - a building like this was not meant to house retarded the way they are housing them now - the building was not built to house the retarded so we cannot say across the board that our ratio of aids to patients shall be thus - it has to be different for different buildings.

Salary of aides may need study to determine if the present salary attracts sufficiently qualified personnel.

OVER-CROWDING

In 1956, Cambridge was considered 47% over-crowded by the Department of Health. In 1958 the Superintendent felt that over one-half of the institution was still 47% over-crowded. This was primarily in older buildings. New buildings are now over-crowded based on capacity for which they were planned and built. McBroom Hall for example has four beds in each three-bed bay. (This does not make it extremely over-crowded but nevertheless when it was laid out and planned it was meant to hold 250 patients and it now has around 287.)

(A brief discussion showed this might be tolerable over-crowding.)

Over-crowding should be studied building by building. In some dormitory areas, there is less than 10 inches between beds.

Dr. Adkins, the Cambridge Superintendent, considers Cambridge at least 18% over-crowded at the present time.

It is felt that an additional 200 bed dormitory could eliminate most over-crowding.

SENATOR CHILD: His figures are 18% and the figure quoted before was 47% over-crowding.

MR. WALSH: The reason I think it is 18% is this - it seems to me that Dr. Cameron has said that he considers our institutions for the retarded 20% over-crowded - since there has not been any real complete survey that we know of we have used this as a minimum figure.

SENATOR CHILD: I find that Dr. Cameron, in the area of employees for instance made the statement repeatedly that we would have to double our employees in order to come up to standards set by the medical group. I have often wondered whether these standards that are being used are the ideal or whether they are geared to the practical aspects of running the institution as economically as possible.

MR. WALSH: I think this would be a good reason for the building by building study - so that somebody can go in and say well now, if we took 10 beds out of here for instance, then we would have 15 inches - now the standard may be different - but this group may say if we put 15 inches between these beds - this approach sounds more practical. Realizing that standards is something we want to bear in mind. Certainly a study building by building would be useful. Then this is our observation solely that we feel an additional 200 bed dormitory could eliminate most over-crowding at Cambridge.

Institution problems tie in with the community problems. We have to find out where we are going - are we going to spend 3 million dollars to develop a community program and if we do does that mean we do not have to spend 3 million dollars on the institutional level - this whole area needs a great deal of study.

SENATOR CHILD: In view of the fact that we have made so much progress in the last 5 years in the release of patients from institutions, don't you think that as this progresses this will have some affect on our over-crowding. Some type of a "crash" program to treat patients - get them out - make them useful citizens. It seems to me if we appropriate money for that type of a program, at least partially, I doubt that we could appropriate enough to satisfy the medical people and psychiatric people - if we go somewhat in that direction of helping them improve their medical and patient treatment, maybe that will to a degree alleviate some over-crowding.

DR. ADKINS: It would seem that as we start aiming toward the "sophisticated" program in our hospitals, so we are not considered an end but as a part of a continual program for the majority of as many patients as possible.

MR. WALSH:

III. MEDICATION AND DRUGS (includes braces, glasses, x-ray supplies, etc.)

In 1955-56 this institution had \$36,000 for drugs - approximately, these figures should be checked - the ratio is right I believe. In 1959-60, with double the number of patients, it has only \$40,000. This is a serious problem.

The present amount for medication and drugs at this institution are about the same as in 1956 when there were half as many patients. This item includes, braces, glasses, x-ray supplies, hearing aids, hospital supplies, etc.

Shortage of money here creates a serious problem, especially when we have more of the more seriously retarded children with multiple handicaps in our institutions.

MR. MARKE: You have only \$40,000 for all uses, that includes x-rays, glasses, etc.?

DR. ADKINS: Yes

SENATOR CHILD: Do you anticipate having to draw on LRC.

DR. ADKINS: We asked LRC for some money. We sent in a request through Chapado's office but it was not presented because of the total burden and so we will again look later on and see how we are getting on - we are using

some savings in other areas to carry us.

SEN. ATOL CHILD: We arranged \$200,00 in a contingent fund. I understand that fund is also available for fixing roofs, etc.

Incidentally, Catalin's office is making a rather stringent attempt to get superintendents, doctors, etc. to buy drugs on the basis of certain standards rather than trade names. I have been told that will make a savings in the purchase of these drugs.

Another thing we took into consideration - in the past these drug companies have been giving a substantial amount of drugs to the institutions for research purposes and I understand that has dropped off sharply in the last year - we were counting on this continuing program - that could run into thousands of dollars.

DR. ATKINS: I had hoped that when we were faced with this problem that we could encourage more companies to come into the hospital but that has not been as helpful as I had hoped. We are doing that in a number of areas - we are about to get a 6 weeks supply of medicine on a research program for around 60 patients and if we find some results then at the end of 6 weeks we would hopefully purchase the drugs and continue it, and our consultants who have ins with the companies from their other areas of work, they will lay this before us, so we attempt to supplement this as much as possible.

SENATOR CHILD: One of the reasons for not having more of this is lack of personnel to keep records. If proper records cannot be kept then the companies say there is no point.

DR. ATKINS: Usually you are asking the staff to do additional work so that there will be research going on - again saving some money.

There was discussion by the Committee on reason for increase of patients at Cambridge - new buildings - number of persons on the waiting list, etc.

MISS COAKLEY: We have a number of factors operating here, one is the factor of public education for which the Parents Association has done such a great job in the last two years, so that we are having a changed attitude toward retardation. People are willing to seek help where even 10 years ago we still had people in back rooms and families trying to disguise it and not getting help for the retarded person. We have made an analysis of the commitment rate for the last 10 years. In 1948 there were approximately 30 commitments per month and for 1959 it is running approximately 51 commitments per month - you see this is a very large increase in committed mentally deficient in the past 10 years. We recognize that we know only a portion of the retarded in the State but with the development of the community resources in the past 10 years there has been a great expansion of services, and I think we believe that retardation is probably staying static - it has increased because of birth rate, the group of retarded becoming known to us is increasing because of changed public attitude.

One thing I would like to comment on, that in our section and in our whole program for the retarded we are approaching it with an entirely different attitude than we would have say 5 years ago. If we had given a definition of retardation within the last 10 years we would have placed great emphasis upon the irresistibility or the fact that this is a basic damage to the brain for which nothing could be done. Now the American Association on Mental Deficiency has just put out a new manual on terminology and classification which will be used for one year for the bugs to be worked out on statistical reporting and then after the bugs are worked out in a year or so we expect that NINH will take it over as a nationwide classification system. The interesting thing is that an entirely new definition of retardation has come forth, where we believe that retardation is a description of a current status of the individual with respect to intellectual functions and adaptive behavior. In other words in the past 10 years with research going on not only on institutionalized retarded but with much more emphasis on the retarded within the community, we now believe that with more skill in diagnostic processing and on the part of all professionals who are working with the retarded, that we may help many retarded develop to a higher level than we ever thought possible before. We are approaching it, all of us within the program, with great respect for what has gone on in the past but trying to take a fresh new look and trying to utilize the improvements in diagnostic skills and improve our own methods in terms of treatment and care. This all relates to programming - I think it relates to the building program - for what function is the institution going to be used - Dr. Adkins has indicated that we believe that we can now have an alive program where people will be staying within our institutions for a much shorter period of time. This relates to the staffing - if we are going to accomplish this it means that we should have good skilled staff and efficient staff to be able to do it. It relates to the community program. In our section for the mentally retarded, we are placing emphasis upon trying to develop resources within the community because we believe that the family where most people belong and that if we can work with families and with the retarded that we may be able to help the whole group and the community function more adequately. I should say that within our Section relating to the waiting list - we expect when Mr. Hursh comes in next month that we will have something for you. We are closely analyzing the waiting list from the viewpoint of working with the counties to see whether we have had the best diagnostic thinking, both in terms of diagnosis and then in treatment or care plan worked out. Instead of saying we will have space in 1960, since we are going to open up at Brainerd, we are now approaching it and have started last fall on this review - will you please report to us the current status of this individual - has there been the best diagnostic services obtained for this individual, if not will you try to secure them - at this point - will you evaluate what is the most desirable plan for this person at this time. We are trying to guide them toward thinking what are all the resources within the State rather than thinking just toward the institutions. We are starting on admissions. We are trying to accentuate our placement program out into the community - our Section is meeting with the Institution people monthly to review who is ready to return to the community and we of the Section are then coordinating the work of the institutions and

the counties and trying to speed up this process. Our goal is to try to see if we can't break down this waiting list so that we can have institution facilities available when they are needed instead of 3 or 5 years later, and that we can have a dynamic program. We realize that there is going to be a small core group who will probably need care for a long period of time, but then for many of the moderate and mildly retarded we believe that institutional facilities will be used for particular purpose and when that purpose is served that person might be able to return to the community. This is our thinking, our philosophy, and we are trying to bring about some changes throughout the State in approach to these problems.

DR. ADKINS: We might insert here for a little additional thinking about numbers - Sandstone closed with 70 mentally retarded patients needing to go to Faribault and Cambridge. Also we have both in Faribault and Cambridge taken in some patients with mental retardation from the mental hospitals, some of the patients were placed in these hospitals many years ago and there just has been no place for them to go. These were retarded people in mentally ill hospitals. Some of them had some severe emotional problems or a superimposed psychotic reaction at the time of commitment were placed in these facilities. Again we are thinking differently as far as our roll toward the mentally retarded. I am not quoting anyone - the mentally retarded are our problem whether they have severe emotional problems or whether they superimposed psychosis we feel that we should handle that rather than have them go into the mental hospital. We are giving electro-shock, we are using tranquilizers, we are seriously considering neuro-surgery - lobotomies.

MR. ANDERSON: Have they had much success with this.

DR. ADKINS: There we come into many variances of opinion. I feel that lobotomies must be considered in our patients if we are going to give them the benefit of all available methods of treatment. I think with psychiatric patients that unless a lobotomy is considered and thought of as a tool that that patient is not being adequately treated. Certainly we know the numbers done now are much less. I am fully convinced that a certain definite percentage of our patients now in Cambridge will eventually be recommended for this type surgery - to relieve them of the feelings and emotions that are causing them to not respond of any other form of treatment.

MR. ANDERSON: Are all the Sandstone patients at Cambridge?

DR. ADKINS: For your information - since I worked the closing of Sandstone - we had 450 patients, approximately 50 of those were inebriates, alcoholics; of the remaining patients 70 were mentally retarded and went either to Faribault or Cambridge. We had 320 mentally ill and we worked like trojans and did we think most commendable job in getting 20%, around 65 or so, out into the community. We did a remarkable job but this indicates what an intensive effort, possibly with reinforcement of pressures for closing the hospital, but it shows what our counties can do in operation. When you think of getting them out - some of them had been in since 1908. The counties cooperated most intensively.

SENATOR CHILD: I heard from several sources that you did a very admirable job up there.

The Committee discussed just how appropriations were made in regard to drugs and other items in connection with the State Hospitals. It was pointed out that it was tightened up during the last Session, possibly too much so. Senator Child said that they would have to figure out some device where they could lend more flexibility.

MR. WALSH: AREAS TO VISIT at the Institution. The Minnesota Association for Retarded Children would like to suggest that the Interim Commission, when it visits Cambridge, consider the following things: Staffing, over-crowding, medication and drugs. We feel that these are the areas of greatest need.

We feel that the greatest benefit from the Interim Commission's visit to Cambridge can come by first touring some of the buildings and observing some of the specific problems first hand. Now in touring these buildings I think that your reaction is probably is going to be the same as mine - you go into a ward and your reaction if it is like mine is going to be how soon can I get out of here - sometimes due to the type of patients, sometimes to the smell, but I think the thing is that it is going to take more than a quick glance. We would like to suggest that the Commission visit the following buildings: 1. Building #12 - here to observe over-crowding in the dormitories and lack of directed activity. When we speak of lack of directed activity we are speaking again of lack of staff because if there were more staff there could be more directed activity. Also you should observe the isolation rooms. This emphasizes the lack of staff. 2. Building #5 - note lack of directed activity, over-crowding in dormitories.

In visiting these two dormitories, if possible, for Interim Commission members to observe duties carried on by aides. It may be possible to inquire from various aides regarding the number of times children and adults must be changed if they wear diapers, number of baths which must be given daily and weekly. For men, the number of times they must be shaved, the number of times various patients must be changed completely from the skin out each day. Discussion of other duties aides have such as preparing children for visits by parents, taking them to hospital or infirmary, taking them to the dining room and helping supervise feeding.

I think it is important here to point out that we feel that the institution personnel do an outstanding job with the available staff.

In noting the isolation rooms it might be pointed out that it appears that children when they present special problems are put in isolation rooms where perhaps if proper staffing was available we could treat the defect or problem, work with the child more rather than isolating him from the rest of the people. Thereby isolating his problem also. By isolating the children who have the most severe behavior problems we are taking away from them any attention by staff, primarily we mean aides.

I know what my reaction was as I looked at the children in these isolations wards and I am not sure but what you will see the same children - this one girl in the isolation room as you looked through the hole in the door, laying

on a mattress, half clothed, half covered with a blanket, another blanket torn up around her - what can be done for a patient like this - what should be done. I am sure that if a person like this gets extremely bad they place her in a hospital - if she gets completely out of hand - I don't know the circumstances behind this one, but I am giving you my reaction. It was one of shame that we in Minnesota has a situation like this - it really was. I think sometimes when we look at these severely retarded people we are inclined to rationalize, say - Oh well, this is all that can be done for them. If anything more is done it would not make any difference to them anyway. All of these people do have the same feelings, at least of comfort and discomfort as we do.

MISS COAKLEY: I am assuming that this isolation is not a part of a treatment plan which is the most suitable plan for the child. The reason that I am raising this question is that both in education and treatment of some brain damage children where too much stimulation, even in surrounding can have a harmful effect and there are times with a brain damaged child that the plan of treatment is to place this child in a room which is relatively bare and to give him, you might say, a time to recuperate his strength within him when he can come back to being with the group - in other words a time free from confusion or tension. I assume that this is not the type of isolation you are speaking of.

MR. WALSH: I think that Dr. Adkins could best answer that - it would be my guess that some of this is involved but I think part of it is the patient has been causing so much trouble in the ward that the aides just say we are going to put this patient down here and after while we will take her out. Dr. Adkins can perhaps answer that more fully - I don't know.

DR. ADKINS: Probably half one and half the other, so to speak. Some of these patients very definitely must be handled in a treatment such as Miss Coakley mentioned - hopefully all of our patients are in a superficial or stretched program. With these individuals I would tend to feel that under the circumstances that that would be stretched programming, but there is certainly a far better way of doing it. All facets of possible treatment could be used - I would like to bring to your attention one specific case that I have been working on. I feel so heartened by it because it shows what appropriate treatment can do, at least in this one individual. We had one girl - I don't know how many years or months, but I know that when I came along and hopefully catalyzed the electro-shock program, at least bringing to bear - here we have a tool which we should use when indicated. This patient had had a number of tranquilizers and various forms of therapy, but never had been given the benefit of electro-shock. She spent all of her time down in the isolation ward. She was put on shock a month ago and now she spends intervals up in the ward - sometimes 15 minutes, sometimes 45 minutes. When she is down in the room it is no longer necessary to lock the door so we are progressing under electro-shock. We don't know where we are going to go with her, but certainly we are considering all aspects of possible schools of treatment. We have made improvement.

These other patients should certainly have the benefit of a good intensive look at and be sure we have used every tool in the treatment in that area. Then, if this is the case, where they must be removed because of the total picture from such environment at intervals, then that is the treatment method.

There was general discussion by the committee about the isolation treatment.

MR. WALSH: If it were possible through better staffing to have fewer children in each category it would be possible again to treat the children and serve them more effectively. When it is necessary to have three aides handling one hundred patients, all the patients must be doing the same thing. Some of these patients could benefit from more activities if sufficient staff were available.

We would like to suggest that the legislators visit McBroon Hall and here note the advantages of the well planned new building, however, even here certain problems exist because of shortage of staff. We feel that the legislators should visit the physical therapy department in this building and observe what is being done in spite of lack of funds in this area. I think that certainly Cambridge is to be commended on their physical therapy program.

These are our suggestions and if there were time there is another building we would like to suggest that you visit Building #7.

SENATOR CRITZER: Are you quite satisfied with the food service.

MR. WALSH: Talking with Dr. Adkins and what we know of other institutions their food service seems to be handled very well. They would like to have some things in the older buildings, dish-washers, etc. brought up to date. This is not what we consider the major problem - food service is going along quite well.

DR. ADKINS: It is interesting with this whole business how it is dovetailing so beautifully. I came to Cambridge and I hang Dr. Radsworth's sweater up and say I am going to develop my own way and so I start taking a look at the Institution so that I can learn more and more about all aspects of it. Along about that time a task force is set up - this is a good thing because in this respect we see a little bit more inside out - now the task force coming into us, made up of the people of the community, our legislators, and a few of us from the institution, myself and one of our charge aides. We set up a tour and I thought it would be better if I would turn this over to a charge aide - here is an institution - here are people and you take charge of this and you take this thing up in any way that you want to - I am going to stay out of this. I said "Try and set this up for a good cross-section. This is the same tour that she set up. I felt that it was so received that it would be the one to give to you folks - it is the one we have set up for this afternoon except for education.

MR. WALSH: I was going to say that we have not suggested that you visit all areas - thinking that you would want to concentrate on the problems. You could spend your whole time looking at hospitals, new classrooms, new buildings, etc. I think it is more important to look at the real problem areas.

lights, etc. that they did not have time for the patients.

MR. WARNE asked if Miss Coakley had anything further to say or anyone else wished to discuss something further.

DR. ADKINS: I would like to emphasize that here we are looking at our so-called stretched program and I repeat what Miss Coakley said - let us respect what has been done in the past but let us not hold anything so sacred that we can't pick it up and look at it and change it when we feel we might make progress.

SENATOR GRITTER: Just what is this stretched program?

DR. ADKINS: It is a program that we are not on the defensive at all. Let me emphasize this - in this whole field we don't know where we are going yet - there are so many things that we have got to look at - we have got to think of integrating this whole program business so that every resource that we have got is most efficiently focused on a patient to make him the best possible.

SENATOR CHILD: Whether it is institution or whether it is county, etc.

DR. ADKINS: As far as I am concerned those persons in institutions.

SENATOR CHILD: In the past so much emphasis has been put on institutions, buildings and getting them into beds -

MISS COAKLEY: May I make one comment which was raised about the time we were discussing Sandstone - At the present time there are 412 mentally deficient individuals in our institutions for the mentally ill and a number of those are on the waiting list as of the date that the institution superintendent requested that they be transferred to an institution for the mentally deficient so that now that we are offering the new spaces from Brainerd which opens next month a few will be transferred out of these institutions for the mentally ill into institutions for the mentally deficient, but if we were going to totally eliminate duplication, there are 412 at the present time in institutions.

SENATOR GRITTER: Why were they put there?

MISS COAKLEY: They were probably put there because there was not available space in an institution for the mentally deficient. I think we are coming more and more to believe as Dr. Adkins' stated that we would like to have skilled enough staff at the facility within our institutions of the mentally deficient that they could also care for those mentally deficient who have emotional problems.

DR. ADKINS: Another problem - here in one of the cottages you will visit about 105 patients - all of the others are open to a degree but this is closed, one male and one female - closed essentially because we have anywhere from 20 to 40 individuals who cannot handle this open door type of a thing.

We are wondering in this long time programming in building and planning if we cannot get this little nucleus of patients in a more intensive treatment area. Separate them so they are not jeopardizing that number who should be having the benefit of other environment.

SENATOR GRITTNER: How about those in Fariabult, why can't we transfer them back and forth and get them all in one place.

MR. WALSH: We have them on a regional basis now.

MISS COAKLEY: May I respond to that by saying in a very small and very limited way, we have been directing some patients to the Cambridge State School and Hospital, perhaps out of the district because of their very close affiliation with the University of Minnesota, and the fact that Dr. Adkins with his interest and background and affiliation with the University has seemed that he could best meet the needs of this person. This has been more in the area of children than with adults, but we have directed a limited number of children to Cambridge rather than the district.

MR. WALSH: Our program is large enough so we should be able to do the same thing for each group in each place. If we had the staff you could have one ward you could put them in. Again this is the same problem.

MR. ANDERSON: Before lunch there is another matter of business we should take up and that is whether we want to send a representative of this particular commission as a delegate to the White House Conference on April 1, 1960. If Senator Grittner goes he can bring a lot of important information that will be valuable to us - he is certainly qualified.

SENATOR CHILD: I MAKE A MOTION THAT SENATOR GRITTNER BE AUTHORIZED AN EXPENSE ACCOUNT TO ATTEND THE WHITE HOUSE CONFERENCE. SECONDED BY MR. ANDERSON. MOTION CARRIED AND SO ORDERED.

SENATOR GRITTNER: I might say that I have been selected as one of the accredited delegates.

MR. WARNEKE: We should consider for a minute these sub-committees we created at the last meeting. I am in the process now of setting them up. The sub-committee on the physically handicapped meets with the Governor's Advisory Committee on the Physically Handicapped next Friday. I will get the rest of them set up and you will all be notified.


THE COMMITTEE DECIDED THAT ALL MEMBERS OF THE COMMITTEE SHOULD RECEIVE NOTICES OF THE SUB-COMMITTEES MEETINGS.

FEBRUARY 10th was selected as the next meeting date to be held at Faribault. At the next meeting Mr. Hursh and Mr. Walsh will discuss in the morning the proposed Division of Mental Retardation within the Department of Welfare. 9:30 A.M. was set as the meeting time.

The Committee toured the Cambridge School and Hospital in the afternoon. At the end of the tour Mr. Gerhard Vingen in charge of education at the school spoke briefly to the Committee.

Meeting adjourned.

Respectfully submitted,


Moony Anderson, Secretary

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